

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified of course.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) NORMAN H. BRANNOCK				2a. DATE OF DEATH MONTH 11 DAY 22 YEAR 86		2b. HOUR 7:18P	
3. SEX m		4. RACE CAUC		5. DATE OF BIRTH MONTH 4 DAY 21 YEAR 07		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.	
10. CITY OR TOWN OF DEATH CAM BRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DG H		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) carpenter-waterman		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD				13b. COUNTY DORCH		13c. CITY OR TOWN CAMB	
14. FATHER'S NAME FIRST EDWIN MIDDLE BRANNOCK LAST BRANNOCK				15. MOTHER'S MAIDEN NAME FIRST CARRIE MIDDLE GEORGEAN LAST GEORGEAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT WIFE		ADDRESS 1008 RACE ST	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 9/12 DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) POSSIBLE CVA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:6 RECENT (L) CVA, CORD							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/18 , 19 86 , to 11/22 , 19 86 , that (I) (we) last saw the deceased alive on 11/22 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If yes, I did) (did not) view the body after death.							
22b. SIGNATURE Yubert J. Jey				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/22/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (STATE IF OTHER) burial		23b. DATE 11/25/86		23c. NAME OF CEMETERY OR CREMATORY MD. VETERANS CEM.		23d. LOCATION CITY OR TOWN BEULAH COUNTY DOR. STATE MD.	
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME ADDRESS CAMBRIDGE MD.				25a. DATE REC'D. BY REGISTRAR NOV 25 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

2 COLLOIDAL

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024384 NOV 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) ROGER A. CORNISH			2a DATE OF DEATH MONTH 11/ DAY 10/ YEAR 86		2b HOUR M
3 SEX M.	4 RACE Negro	5 DATE OF BIRTH MONTH 2 DAY 23 YEAR 1935		6 AGE (IN YEARS LAST BIRTHDAY) 51 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b CITIZEN OF WHAT COUNTRY? XXXXXUSA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.	
10 CITY OR TOWN OF DEATH Cambridge	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stevadore	12b KIND OF BUSINESS OR INDUSTRY Retired	
13a STATE Md.		13b COUNTY Dor.	13c CITY OR TOWN Cambridge	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 808 High St. Camb., Md. 21613
14 FATHER'S NAME FIRST Rufus MIDDLE R. LAST Cornish		15 MOTHER'S MAIDEN NAME FIRST Mary MIDDLE J. LAST Travers			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO 214-32-0643		17 INFORMANT Mary Jean Cornish ADDRESS 228-7565 (Sister) 21613	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive (R) Cerebral CVA DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 11-2 , 19 86 , to 11-10 , 19 86 , that (I/we) last saw the deceased alive on 11-10 , 19 86 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (I, we) (did, did not) view the body after death.					
22b SIGNATURE Mary Ann D. Moore		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 11-10/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MARY ANN D. MOORE MD		22e ADDRESS 404 BYRN ST., CAMBRIDGE, MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 11/13/86	23c NAME OF CEMETERY OR CREMATORY Bethel A.M. Cem.		23d LOCATION CITY OR TOWN Cambridge COUNTY Dor. STATE Md.
24 FUNERAL DIRECTOR L.H. BOARDLEY F/H CAMB., MD. 21613				25a DATE REC'D. BY REGISTRAR NOV 18 1986	25b REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 as a contributing cause of death, the medical examiner must be notified immediately.

BP

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054234 NOV 19 03



NOV 19 03

NOV 19 03

026513 DEC -9 85

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LEONA Hazel DEAN			2a. DATE OF DEATH MONTH DAY YEAR 11 - 29 - 86		2b. HOUR 2:45 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1/6/1913	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD		
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Dorchester	13c. CITY OR TOWN Honga	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Luther Jones			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Todd		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-14-8427	17. INFORMANT ADDRESS Rt 3 Box 116 A Eldridge M. Johnson Cambridge, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTIC SHOCK DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 hours. 2 days.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CHRONIC OBSTRUCTIVE PULMONARY DISEASE					
19a. DATE OF OPERATION —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — — —			
22a. I certify that (I) (this hospital) attended the deceased from 11-26 19 86 , to 11-29 19 86 , that (I) (we) last saw the deceased alive on 11-29 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Michael A. Moskewicz			DEGREE —	22c. DATE SIGNED 11-29-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSKEWICZ MD			22e. ADDRESS 503 BYEN ST. CAMBRIDGE MD 21613		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/1/86	23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem Park Cambridge, Dor. Md.		23d. LOCATION CITY OR TOWN COUNTY STATE — — — — —	
24. FUNERAL DIRECTOR NAME ADDRESS Thomas Funeral Home Cambridge, Md.			25. DATE REC'D. BY REGISTRAR DEC 8 1986		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

WASH
25-10-13

TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

BY: [illegible]

FOR: [illegible]

THROUGH: [illegible]

BY: [illegible]

FOR: [illegible]

THROUGH: [illegible]

BY: [illegible]

FOR: [illegible]

THROUGH: [illegible]

BY: [illegible]

FOR: [illegible]

THROUGH: [illegible]

BY: [illegible]

024139 NOV 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Henry Levi Dixon			2a. DATE OF DEATH MONTH DAY YEAR Nov. 11, 1986		2b. HOUR 0430 M
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Mar 28 1912	6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.		
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) tool maker		12b. KIND OF BUSINESS OR INDUSTRY mfg.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Dor.	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 419 Robbins St. 21613	
14. FATHER'S NAME FIRST MIDDLE LAST William Dixon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Dixon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2	17. INFORMANT ADDRESS Sadie H. Dixon Item # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>KETOACIDOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIABETES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>1 day</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>Nov 10, 1986</u> , to <u>Nov 11, 1986</u> , that (1) (we) last saw the deceased alive on <u>Nov 11, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Michael A. Moskewicz MD</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11-12-86</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael A. Moskewicz MD</u>			22e. ADDRESS <u>503 BYEN ST. CAMBRIDGE MD.</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE 11/13/86	23c. NAME OF CEMETERY OR CREMATORY MD. VETERANS CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BEULAH DOR. MD.	
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			25a. DATE REC'D. BY REGISTRAR NOV 17 1986		
ADDRESS CAMBRIDGE MD.			25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic or medical condition, the death certificate must be certified at place

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove each page 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

BP

Hourly Level Elevation

Time of day

Direction of flow

Water level

Water level

Water level

Water level

Water level

Water level

Water level

Water level

Water level

Water level

Water level

Water level

Water level

Water level

Water level

Water level

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please inform the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other cause of death, the medical examiner must be notified of same.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) <u>DOROTHY</u>		LAST <u>ELLIS</u>		<u>11 3 86</u>		<u>2 40</u> M	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
				MONTH DAY YEAR		88	
		Jan. 5, 1898				YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>DORCHESTER</u> MD.	
10. CITY OR TOWN OF DEATH <u>Cambridge</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Dorchester General Hosp.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Secretary</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Ice Making</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u> 13b. COUNTY <u>Dorchester</u> 13c. CITY OR TOWN <u>Cambridge</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>101 Choptank Ave. 21613</u>			
14. FATHER'S NAME FIRST <u>Robert</u> MIDDLE <u>Yeager</u> LAST <u>Rowe</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Martha</u> MIDDLE <u>Rowe</u> LAST <u>Rowe</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. <u>265-41-9962</u>		17. INFORMANT ADDRESS <u>Mr. Warren Ellis same as #13</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR COLLAPSE</u>						<u>TERMINAL</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u>						<u>DAYS</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEVERE DECUBITUS ULCERS</u>						<u>MONTHS.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>ORGANIC BRAIN SYNDROME, CVA & LEFT HEMIPARESIS</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>9-12</u> , 19 <u>86</u> , to <u>11-3</u> , 19 <u>86</u> , that (1) (we) lost <u>saw</u> the deceased <u>above</u> <u>11-2</u> , 19 <u>86</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>JAMES F. McCLARTER, M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>11-3-86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAMES F. McCLARTER, M.D.</u>				22e. ADDRESS <u>400 AURORA STREET CAMBRIDGE, MD, 21613</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>10-4-86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Salisbury Crematory</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Salisbury, Wicomico, Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Curran Funeral Home</u> ADDRESS <u>308 High St. Cambridge, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>NOV 5 1986</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jessie A. Feaga			2a. DATE OF DEATH MONTH DAY YEAR November 5, 1986		2b. HOUR P 7:00 M							
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 23 03		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD.						
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Currency Proc.		12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't				
13a. STATE MD			13b. COUNTY Dorchester		13c. CITY OR TOWN Hurlock		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 105 Poplar Street/21643			
14. FATHER'S NAME FIRST MIDDLE LAST James A. Bell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ruffner			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT P. O. Box 313 Helen Shenk Hurlock, MD 21643	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Peripartum and Perinatal Vasc. Dysfunction</u>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Peripartum and Perinatal Vasc. Dysfunction</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (a) (this hospital) attended the deceased from <u>10-2-86</u> to <u>11-5-86</u> , that (b) (we) last saw the deceased alive on <u>11-3-86</u> , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Michael J. Fadden</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11-5-86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael J. Fadden, M.D.				22e. ADDRESS 302 Collins Avenue, Hurlock, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-8-86		23c. NAME OF CEMETERY OR CREMATORY Unity Washington		23d. LOCATION CITY OR TOWN COUNTY STATE Hurlock, Dorchester, MD						
24. FUNERAL DIRECTOR Zeller Funeral Home, East New Market, MD				25a. DATE REC'D. BY REGISTRAR NOV 13 1986				25b. REGISTRAR'S SIGNATURE <u>Randall</u>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked on item 18 showing injury, or other traumatic event, the medical examiner must be notified at once.

BP

024768 NOV 21 1986

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLEY WESLEY HURLEY JR			2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 11-10-86		2b. HOUR 3:30 PM
3. SEX M	4. RACE Cauc	5. DATE OF BIRTH MONTH DAY YEAR 7-7-22 64 YRS.	6. AGE (IN YEARS) LAST BIRTHDAY 64 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER	
13a. STATE MD		13b. COUNTY DORCHESTER		13c. CITY OR TOWN EAST NEW MARKET	
14. FATHER'S NAME WILLIS WESLEY HURLEY		15. MOTHER'S MAIDEN NAME ETHEL MCCREARY		16. SOCIAL SECURITY NO. 217-36-1264	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-36-1264		17. INFORMANT (DAUGHTER) FAVE DODSON	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION WITH STANDING DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) GENETIC ABNORMALITY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 6 yrs 6 yrs			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? N/A		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) N/A	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE Donald R. McWilliams		TITLE (SPECIFY) DEPUTY		MEDICAL EXAMINER DATE SIGNED 11/11/86	
EXAMINER'S NAME (TYPE OR PRINT) Donald R. McWilliams MD		ADDRESS 366 GAY ST. CAMBRIDGE, MD 21613			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-13-86		23c. NAME OF CEMETERY OR CREMATORY East New Market Cem.	
24. FUNERAL DIRECTOR Zeller Funeral Home, East New Market, MD		25a. DATE REC'D. BY REGISTRAR NOV 20 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENAL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM #A 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) HOWARD		FIRST Howard MIDDLE Edward LAST Johnson		2a. DATE OF DEATH MONTH 11 DAY 11 YEAR 1986		2b. HOUR 2:05 MIN. A	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH 8 DAY 19 YEAR 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory Work		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Md.				13b. COUNTY Dor.		13c. CITY OR TOWN Camb.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Author MIDDLE Johnson LAST Turner				15. MOTHER'S MAIDEN NAME FIRST Bertha MIDDLE Turner LAST Turner				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 217-10-8846				17. INFORMANT (Spouse) ADDRESS 21613 Vrooma Johnson 449 High St. Camb. Md.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO MYOPATHY & CHF DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (c) O.B.S. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None									
19a. DATE OF OPERATION 10-37		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH 10 DAY 19 YEAR 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) None					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) None		21f. LOCATION STREET None CITY OR TOWN None COUNTY None STATE None					
22a. I certify that (I) (this hospital) attended the deceased from 10-37 , 19 86 , to 11-7 , 19 86 , that (I) (we) last saw the deceased alive on 11-7 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Mehta Vinodrai				DEGREE None				22c. DATE SIGNED 11/11/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mehta Vinodrai				22e. ADDRESS 400 Aurora St. Camb.. Md. 21613					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/15/86		23c. NAME OF CEMETERY OR CREMATORY Bethel AME Cem.		23d. LOCATION CITY OR TOWN Camb., COUNTY Dor. STATE Md.		24. FUNERAL DIRECTOR NAME L.H. Boardley F/H Camb., Md. 21613 ADDRESS None	
25a. DATE REC'D. BY REGISTRAR NOV 18 1986				25b. REGISTRAR'S SIGNATURE None					

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025199 NOV 25 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) CLARENCE EUGENE JONES JR.			2a DATE OF DEATH MONTH 11 DAY 21 YEAR 86		2b HOUR 1830
3 SEX M	4 RACE W	5 DATE OF BIRTH MONTH 2 DAY 20 YEAR 16		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.	
10 CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) carpenter		12b KIND OF BUSINESS OR INDUSTRY State of MD
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. 13b COUNTY Dor. 13c CITY OR TOWN Cambridge			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST Clarence MIDDLE Eugene LAST Jones			15 MOTHER'S MAIDEN NAME FIRST Della MIDDLE Cannon LAST Cannon		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW 2 217108695		17. INFORMANT ADDRESS Margaret Jones Item # 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) RESPIRATORY FAILURE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 D
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (2) PNEUMOTHORAX					21 D
DUE TO, OR AS A CONSEQUENCE OF (c) EMPHYSEMA.					YRS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: HEART FAILURE					
19a DATE OF OPERATION 11-1-86		19b CONDITION FOR WHICH OPERATION WAS PERFORMED (2) PNEUMOTHORAX		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 11-1-86 to 11-21-86 , that (I) (we) lost saw the deceased alive on 11-21-86 above, (I) (we) (did) (did not) view the body after death. and that in (my) (your) opinion death occurred on the date and hour and from the causes stated					
22b SIGNATURE David F. Harper		DEGREE MD		22c DATE SIGNED 11-21-86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DAVID F. HARPER JR		22e ADDRESS 402 BYRN ST. CAMBRIDGE MD 21613			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE 11/24/86		23c NAME OF CEMETERY OR CREMATORY JONES FAMILY CEM.	
23d LOCATION CITY OR TOWN CAMBRIDGE COUNTY DOR. STATE MD.		24 FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME ADDRESS CAMBRIDGE MD.			
25a DATE REC'D. BY REGISTRAR NOV 25 1986		25b REGISTRAR'S SIGNATURE Julia Davidson-Rudolph			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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024074 NOV 14 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (Type or Print) LOUISE Elizabeth LOWE			2a. DATE OF DEATH MONTH DAY YEAR 11 7 86			2b. HOUR 8:20 PM			
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 21 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD.			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 701 Race Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Harris				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Rickens					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-36-0388		17. INFORMANT ADDRESS Robert M. Lowe Rt 4 Box 36 21613 Cambridge, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES 405		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS, OBESITY, HYPERTENSION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 11/7 to 19 86, that (I) (we) last saw the deceased alive on 10/10/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE Hubert L. Piercy M.D.						22c. DATE SIGNED 11/7/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUBERT L. PIERCY						22e. ADDRESS 503 BYRN STREET CAMBRIDGE MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/11/86		23c. NAME OF CEMETERY OR CREMATORY Dor. Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dor. Md.		
24. FUNERAL DIRECTOR NAME Thomas Funeral Home Cambridge Md.						25a. DATE REC'D. BY REGISTRAR NOV 14 1986			
						25b. REGISTRAR'S SIGNATURE J. Anderson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALTHEA ANNA MURRELLS			2a. DATE OF DEATH MONTH DAY YEAR NOV. 8, 1986			2b. HOUR 0345 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUG 6, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.	
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKERS	
13a. STATE MD.				13b. COUNTY DOR.		13c. CITY OR TOWN WOOLFORD	
14. FATHER'S NAME FIRST MIDDLE LAST ADOLPH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA BECK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-28-6611		17. INFORMANT ADDRESS ANTHONY P. MURRELLS ITEM #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Cancer of Endometrium of the uterus. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5/83 - death
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DEGREE JOSE M. DE LEON, M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/11/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSE M. DE LEON, M.D.				22e. ADDRESS 505 BIRN, CAMBRIDGE, M.D. 21613			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/10/86		23c. NAME OF CEMETERY OR CREMATORY EMMITTSBURG MEMORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE EMMITTSBURG FREDERICK M.D.	
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME				ADDRESS CAMBRIDGE M.D.		25a. DATE REC'D. BY REGISTRAR NOV 14 1986	
				25b. REGISTRAR'S SIGNATURE			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

DHM - 16 50M 7/77
(VR A 15 (4))

034052-13416-08

11

23759 NOV 13 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 is marked, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77
(VRA 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 2 1 3 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth Jane Reese			2a. DATE OF DEATH MONTH DAY YEAR Nov. 1, 1986		2b. HOUR 0345 ^M		
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Jan 9, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U . S . A .		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD	
10. CITY OR TOWN OF DEATH Taylors Island		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bayshore Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. CITY OR TOWN Brooklyn Pk		13c. STREET ADDRESS 6 12th Ave. 21225			
14. FATHER'S NAME FIRST MIDDLE LAST James Geoghegan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE Nottie Phillips				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-03-0960		17. INFORMANT ADDRESS Box 93 B George J. Reese Taylors Is. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MULTIPLE MYELOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos 4 wks. 1981
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from <u>10-14</u> , 19 <u>86</u> , to <u>11-1</u> , 19 <u>86</u> , that (b) (we) lost saw the deceased alive on <u>10-14</u> , 19 <u>86</u> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (we) did not view the body after death.							
22b. SIGNATURE Michael A. Moskewicz MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-3-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSKEWICZ				22e. ADDRESS 503 134th ST CAMBRIDGE MA			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 11/4/86		23c. NAME OF CEMETERY OR CREMATORY Brick Churchyard		23d. LOCATION CITY OR TOWN COUNTY STATE Taylors Island, Dor., Md.	
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME				ADDRESS CAMBRIDGE MD.		25a. DATE REC'D BY REGISTRAR NOV 10 1986	
25b. REGISTRAR'S SIGNATURE Gina Gordon-Randall							

MEDICAL CERTIFICATION

8 6 3 2 1 3 8

025729 DEC 13 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Rachel Preston Richardson			2a. DATE OF DEATH MONTH 11 DAY 25 YEAR 86			2b. HOUR 8.45 AM					
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH Feb DAY 9 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 		8. IF UNDER 24 HRS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.					
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Dor. 13c. CITY OR TOWN Cambridge											
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
13e. STREET ADDRESS / ZIP CODE Cassons Neck Rd. 21613 (Rt 3 Bx 223)											
14. FATHER'S NAME FIRST Charles MIDDLE F. LAST Preston						15. MOTHER'S MAIDEN NAME FIRST Henrietta MIDDLE LAST Morgan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 404010271				17. INFORMANT ADDRESS Dana P. Richardson Item # 13			

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

C H Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

ASCVD - V. Arrhythmia

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Organic B. Syndrom, old CVA

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. Tammann				DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation		23b. DATE 11/25/86		23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory		23d. LOCATION CITY OR TOWN Lewes COUNTY Sussex STATE Del.	
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME ADDRESS CAMBRIDGE MD.				25a. DATE REC'D. BY REGISTRAR DEC 01 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandora	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their place is retained on the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, entombment, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or any trauma or event, the medical examiner must be notified and a medical examination must be performed.

BP

05218 REC-300



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GERTRUDE A. STANLEY			2a. DATE OF DEATH MONTH 11 DAY 3 YEAR 86			2b. HOUR 5²³ PM					
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH OCT DAY 14 YEAR 1937		6. AGE (IN YEARS LAST BIRTHDAY) 49		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		8. IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.					
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Gen Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Dorchester 13c. CITY OR TOWN Cambridge				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1615 Bayly Rd / 21613					
14. FATHER'S NAME FIRST Herman MIDDLE Pirder LAST Pirder				15. MOTHER'S MAIDEN NAME FIRST Loise MIDDLE Woolford LAST Woolford							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 218-34-8922		17. INFORMANT ADDRESS Norman Stanley 1615 Bayly Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CACHEXIA DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC ADENOCARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) PERFORATED ADENOCARCINOMA OF COLON										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0											
19a. DATE OF OPERATION 8-1-86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATED ADENOCARCINOMA OF COLON & ABSCESS FORMATION			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital) attended the deceased from 7-30 19 86 , to 11-3 19 86 , that (2) (we) lost saw the deceased alive on 11-3 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (we) did not view the body after death.											
22b. SIGNATURE James F. McArthur, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES F. MCARTHER, M.D.						22e. ADDRESS 400 AURORA ST. CAMBRIDGE, MD, 21613					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/8/86		23c. NAME OF CEMETERY OR CREMATORY Fork Neck Ceme			23d. LOCATION CITY OR TOWN Vienna COUNTY Dorchester STATE MD.			
24. FUNERAL DIRECTOR NAME Stewart Funeral Home ADDRESS Cambridge Md.						25a. DATE REC'D. BY REGISTRAR NOV 6 1986			25b. REGISTRAR'S SIGNATURE John Sander		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove captioned papers, pages 1 and 2, should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



026647 DEC 16

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86-32140
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Virginia M. Stanley			2a. DATE OF DEATH MONTH DAY YEAR 11-30-86		2b. HOUR 1130 A.M.		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR July 27, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Linkwood, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Linkwood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Stewart				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Jones			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-28-4357		17. INFORMANT ADDRESS Linkwood 21835 Rt. 1, Box 101, Md/			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Renal Failure

DUE TO, OR AS A CONSEQUENCE OF

(b) MULTIPLE MYELOMA

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Months

1981

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 11-29, 1986, to 11-30, 1986, that (2) (we) last saw the deceased alive on 11-29, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death.							
22b. SIGNATURE Michael A. Moskewicz				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-30-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSKEWICZ				22e. ADDRESS 503 BYEN ST. CAMBRIDGE MD 21613			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 5, 1986		23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Salem, Dorchester, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Hampton-Thurbin 216 N. Main St. Fed., Md				25a. DATE REC'D. BY REGISTRAR DEC 04 1986			
				25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it will be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4 should be filed with the funeral director. Page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be notified of one.

0366-1345(199209)10:03:1-0